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ABSTRACT

Two-hour semi-structured interviews were conducted with a heterogeneous group of psychotherapists to investigate their experience of therapeutic practice, and in particular to study the phenomenon of emotional and physical exhaustion known as "burnout," in which professionals lose all concern, all emotional feelings for the persons with whom they work and come to treat them in detached or de-humanizing ways. Data showed that burnout was attributed primarily to the nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. Most therapists cited lack of therapeutic success as the single most stressful aspect of their work. A majority of therapists felt that the use of support systems (e.g., supervisory relationships, support of colleagues) was essential to their own mental health. The data further suggest that there are certain inherent difficulties in all work with patients, relating to the nature of the therapeutic role and to the fact that the therapeutic process is slow and erratic. To prevent or minimize burnout, therapists in both the public and private sectors must be able to express, freely, negative feelings toward their work. (Author/CS)

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THE PROCESS AND DIMENSIONS OF BURNOUT IN PSYCHOTHERAPISTS

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THE PROCESS AND DIMENSIONS OF BURNOUT IN PSYCHOTHERAPISTS

As part of a comprehensive project to investigate the effects of psychotherapy upon psychotherapists, the present study was designed to focus on the phenomenon of therapist burnout. Freudenberger (1974) originally coined the term "burnout" to describe the emotional and physical exhaustion of staff members of alternative healthcare institutions. In recent years a small but growing number of investigators have studied the burnout phenomenon (Cherniss, Egnatios, & Wacker, 1976; Cherniss, Egnatios, Wacker, & Dowd, in press; Edelwich & Brodsky, 1980; Freudenberger, 1974, 1977; Kahn, 1978; Maslach, 1976, 1978; Maslach & Pines, 1977; Mattingly, 1977; Pines & Kafry, 1978). Maslach (1976), for example, in studying a broad range of health and social service professionals, found that burned-out professionals "lose all concern, all emotional feelings for the persons they work with and come to treat them in detached or even de-humanized ways" (p. 16). Burned-out professionals may become cynical toward their clients, blaming them for creating their own difficulties or labelling them in derogatory terms; or, in order to maintain a safe emotional distance from an unsettling client, professionals may increasingly resort to technical jargon and refer to clients in diagnostic terms. Furthermore, the emotional frustrations attendant to this phenomenon may lead to psychosomatic symptoms (e.g., exhaustion, insomnia, ulcers, headaches) as well as to increased family conflicts.

Burnout has become a problem of increasing public and professional concern. Indeed, it may well become a "catch-phrase" of the 1980's (Kennedy, 1979). There is, however, a notable paucity of research on stress and burnout in psychotherapists. This gap exists despite the fact that over forty years ago Freud (1937/1963) wrote of the "dangers of analysis" for analysts. Despite

the fact that the inner experience of the therapist has come to be acknowledged as an important variable in the psychotherapeutic process (Burton, 1972) and despite, too, the fact that the manpower shortage in the mental health field (Albee, 1959, 1968; Hobbs, 1964) critically increases the need to maximize the job satisfaction and efficiency of available personnel.

The literature bearing on the issue of therapist stress and burnout consists primarily of impressionistic accounts of the difficulties of therapeutic work (Freudenberger & Robbins, 1979; Kubie, 1971; Greenson, 1966; Schlict, 1968; Wheelis, 1958, 1963); reflections on the specific difficulties encountered by beginning psychotherapists (Adams, 1974; Book, 1973; Chessick, 1971; Halleck & Woods, 1962; Merklin & Little, 1967; Roback, Webersinn, & Guion, 1971; Ungerleider, 1965); and observations, unsupported by research evidence, regarding the disillusioned state of the psychotherapeutic community (Frank, 1963; Kernberg, 1968; Rogow, 1970). In addition, there is a small job-satisfaction literature that has focused exclusively on psychiatrists (Daniels, 1974; Maciver & Redlich, 1959; Rogow, 1970). In short, despite the growing popularity of psychotherapy--as both a career choice for students and as a response alternative for troubled individuals--no previous research has investigated the nature of burnout in a heterogenous group of psychotherapists.

Method

Subjects

Subjects were drawn from a Northeastern metropolitan community of approximately 350,000. The list of potential subjects was compiled from the rosters of three major treatment facilities in the area as well as from a composite list,

derived from several sources, of privately practicing psychotherapists in the area. All psychiatrists, psychologists, and social workers from these lists (N = 215) were considered eligible for the study. A total of 95 randomly selected therapists were contacted initially by letter, then by phone, and sixty (63.2%) agreed to participate in the study. No significant differences were found in comparing the acceptance rates of male and female therapists, of private and institutionally-based therapists, or of psychiatrists, psychologists, and social workers. However, among potential participants, a significantly lower percentage of psychiatrists agreed to participate than did nonmedical therapists, $\chi^2(1) = 8.20$, $p < .01$.

The final sample consisted of 36 men and 24 women, including 21 psychiatrists, 24 psychologists, and 15 social workers. Chi-square analysis revealed that males in the present sample were disproportinately represented among the psychiatrists while females were disproportionately represented among social workers, $\chi^2(2) = p < .001$. Among these professionals, 41 considered their practices primarily institutional, 17 as primarily private, and 2 as evenly split. Historically, psychotherapists have tended to be disproportionately Jewish (Henry, Sims, & Spray, 1971)--in the present study 31 of the 60 therapists identified themselves as Jewish, 18 as having no religious affiliation, 9 as Protestant, and 2 as Catholic. The mean age of therapists in the present study was slightly over 38; therapists had been in the field an average of 10 years. They averaged 21 patient hours per week. Reflective of the sizable analytic community in the area under study, 40 of the 60 therapists considered their primary theoretical orientation to be either "classical analytic" or "psychodynamic."

Procedure

After completing a "Therapist Background Sheet," therapists participated in two separate one-hour semi-structured taperecorded interviews that focused on their experiences of work and their perceptions regarding the effects of the psychotherapeutic role. Interviews took place in therapists' offices and at their convenience. All interviews were conducted by the senior author.

Transcripts of several completed interviews provided the basis for a series of preliminary coding systems that were progressively refined to maximize interrater reliability. With the establishment of a final coding system, all interviews were coded directly from the tapes by two independent research assistants trained for the task. After all tapes were coded and frequency counts made of responses to each question, certain conceptually related response categories were combined in order to aid in the analysis of the data. Chi-square analyses were then used to compare response patterns among the following subgroups: male and female therapists; psychiatrists, psychologists, and social workers; private and institutionally-based therapists; therapists with light caseloads (fewer than 16 patient-hours per week), moderate caseloads (16-25 hours per week), and heavy caseloads (more than 25 patient-hours per week); and inexperienced therapists (fewer that 4 years of experience), experienced therapists (4 to 10 years), and veteran therapists (more than 10 years of experience).

Reliability

Interview questions generated both nominal and ordinal data. The nominal data were of two types: data resulting from questions permitting

only single response (exclusive response categories) and data resulting from questions permitting multiple responses (multiple response categories).

Interrater reliability for the multiple response category nominal data was measured by overall percentage of agreement between two independent raters. Computed on this basis, reliability was 71.2%. Interrater reliability for both the exclusive response category nominal data and the ordinal data was measured by Kappa (Cohen, 1960), utilizing a computer program developed by Cichetti, Aivano, and Vitale (1977). The range of observed agreement on 21 items tested was between .69 and 1.00; the proportion of items that were statistically significant at the .05 level or better was 18/21. Those items that failed to produce a statistically significant level of reliability were eliminated from the study.

Results

The majority of therapists interviewed (57.4%) attributed the occurrence of burnout to the nonreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. Other factors cited included overwork (22.2%), the general difficulty of dealing with patient problems (20.4%), discouragement as a function of the slow and erratic pace of therapeutic work (18.5%), the tendency of therapeutic work to raise personal issues in psychotherapists (13.0%), the general passivity of therapeutic work (13.0%), and the isolation involved in therapeutic work (11.1%).

Therapists felt that they were especially prone to transient feelings of burnout when stresses at home lowered their threshold for coping with daily therapeutic frustration and impaired their ability to attend effectively to

the needs of their patients. Without the impingement of these external stresses, most (63.6%) felt they could see a maximum of 4-6 patients a day before becoming depleted. A smaller minority felt they could see 7-8 patients (18.2%) or even 9-10 patients per day (7.3%) before feeling depleted. The balance of the sample declined to cite a specific figure, contending that their maximum number of patient hours was variable, though primarily a function of the type, frequency, and spacing of patients. No relevant background variable significantly affected therapists' views regarding a maximum number of patient hours. Many therapists (40.8%) felt that they were particularly prone to burnout during winter months; a smaller proportion felt that they were most vulnerable to burnout in the spring (16.3%) or summer (14.3%).

Most therapists (73.7%) cited "lack of therapeutic success" as the single most stressful aspect of therapeutic work. In this regard too, 25% of the therapists in the sample admitted to occasionally feeling disillusioned with the therapeutic enterprise. Moreover, an additional 55%, although denying current feelings of disillusionment, felt that they had need to reassess the goals and limitations of psychotherapy in order to guard against such feelings. Twenty percent of the sample reported no feelings of disillusionment; many therapists in this category stated in one form or another that they were not disillusioned because they felt that therapy, as they practiced it, "works." For the purposes of statistical analyses, the first two response categories, i.e., "overt disillusionment" and "defending against feelings of disillusionment," were combined. Subsequent chi-square analyses indicated that

neither profession, nor sex, nor caseload, nor experience level significantly affected the proportion of the sample that tended toward disillusionment in one form or another. Whether a therapist had been in personal psychotherapy or not, also did not affect the tendency toward disillusionment. Only clinical setting significantly affected this disposition, with institutionally-based therapists more frequently admitting to either overt feelings of disillusionment or the necessity of defending against such feelings, $\chi^2(1) = 8.44$, $p < .01$.

Most therapists found the role of support systems essential. All those who could, utilized supervisory relationships to help them through difficult moments; of those who were not currently being supervised, 51.1% relied on the informal support of colleagues. In addition to a social support system that served to attenuate anxieties and restore faith, virtually all therapists expressed the need for an activity outlet, such as hobbies or sports, which could provide for relief of stored-up tensions.

Discussion

The primary source of stress for therapists is lack of therapeutic success, i.e., the inability to promote positive change in patients. And the primary factor underlying burnout, according to therapists, is the nonreciprocated attentiveness and giving that is inherent within the therapeutic relationship. Taken together, these findings suggest that therapists expect their work to be difficult, and even stressful, but they also expect their efforts to "pay off." Constant giving without the compensation of success apparently produces burnout.

The data suggest that there are certain inherent difficulties in all work with patients, primarily difficulties relating to the nature of the therapeutic role (e.g., the requirements of attentiveness, responsibility, detached concern) and difficulties relating to the nature of the therapeutic process (e.g., the slow, often erratic pace of therapeutic progress). In addition, working conditions (e.g., excessive workload, organizational politics) can create additional sources of stress, particularly for institutionally-based therapists. However, these stresses are, for the most part, accepted as inevitable and even necessary components of the job; they can, in normal circumstances, be dealt with moderately well with only minimal erosion of one's faith in psychotherapy. It is when psychotherapeutic work is particularly frustrating and only minimally successful--and this may often be the case when one is overworked or dealing with suicidal, homicidal, depressed, or especially resistant patients--that disillusionment and burnout occur.

Frank (1963) stated that those who seek psychotherapeutic care have, as a common characteristic, feelings of demoralization: "They feel powerless to change the situation or themselves" (p. 314). The data of the present study suggest that an analogous process may occur with mental health workers, viz., that those who become burned out have as a common denominator perceptions that their efforts are inconsequential.

Keeping in mind that such dysfunctional aspects of therapeutic work as disillusionment and burnout constitute but one segment--and perhaps not even the major segment--of the therapist's phenomenological world, a

question that still bears asking is, how might these stressful phenomena be prevented or minimized?

First, the problem must be made more public. Therapists in both the public and private sectors must be able to freely express negative feelings toward their work without fear that such admissions will either go unacknowledged or be interpreted as incompetence. One does not hear of many case conferences or read many published case reports where therapists discuss their failures, fears, or doubts. As Sarason (1977) has noted: "To express dissatisfaction or boredom with, or a waning interest in one's work--particularly if one's work is judged by society as fascinating and important, as is the case of many professionals--is no easy matter" (p. 57). Despite these obstacles, ongoing, candid evaluation of work must be built into the structure of the profession. Seminars and conferences might begin to focus on common problems as well as appropriate techniques, on the inevitability and cybernetic value of failures as well as successes, on the limitations rather than the infinite possibilities of the psychotherapeutic process. Such discussion might promote the notion that therapists are both fallible and vulnerable, and might facilitate individual acknowledgment of the salience of these issues. These changes will certainly not come easily--organizations as well as individuals have strong tendencies toward maintaining the status quo--but they would seem necessary. Greber (1976), for example, contends that the only way to prevent demoralization among therapists is by "continual insistence upon seeing and describing conditions of [therapeutic] work as they really are" (p. 434).

An additional method of dealing with the occupational stresses of therapeutic work is through professional support groups. McCarley (1975), for example, has recommended that therapists periodically re-examine their feelings either in a supportive therapeutic group atmosphere or within the context of "refresher" courses with colleagues. Sarason, Carroll, Maton, Cohen, and Lorentz (1977) have radically extended this general notion of support systems with their concept of "human services and resource networks"--individuals and organizations working together to exchange resources, solve mutual problems, and lessen isolation. As Sarason et al. have shown, a successful network can not only reduce individuals' discontent and alienation by creating a psychological sense of community, but it can also increase available manpower by fostering an environment in which individuals share with and learn from one another.

Another focus of potential change is within graduate training programs. These institutions are similar to professional settings in their traditional reluctance to confront the potentially dysfunctional or distressful aspects of therapeutic work. Pre-professionals are assigned appropriate reading material, but they are rarely prepared for the inevitable disappointments they will encounter in the course of their therapeutic work. Burdened with unrealistic expectations, they may be especially vulnerable to early disillusionment and high rates of burnout (Cherniss et al., in press). To mitigate these possibilities, graduate programs too will have to attend more to the limitations and stresses of psychotherapeutic role.

Finally, it should be emphasized that therapists need activities and interests outside the sphere of psychotherapy in order to renew themselves--

to escape, at least temporarily, the stresses of therapeutic work and to prevent the therapeutic mode from totally dominating their perspective. Suggestions for these extra-therapeutic pursuits include greater involvement in social and recreational activities; an increased emphasis on interdisciplinary contacts; and even psychological work such as consulting, teaching, and research that takes place outside the confines of the therapist's office (Grinberg, 1963; Marmor, 1953; Rose, 1974). Professional activities other than therapeutic work might continue to affirm the therapist's sense of expertise but in less emotionally draining contexts.

Dissatisfaction and burnout among therapists may potentiate "radical career changes" among therapists as well as increased demands for alternative sources of satisfaction (Sarason, 1977). However, the most critical impact of therapist burnout may well be on the service delivery system. At present, there is an insufficient number of personnel to manage the responsibility of patient care; moreover, future prospects for lessening the severity of this problem appear nil (Albee, 1959, 1968). Thus, the existing (and likely permanent) manpower shortage mandates optimal performance from those already in the field. Therapist burnout will, if it has not done so already, surely affect substantially the delivery of mental health services, particularly to that growing segment of the population that can ill-afford to bear the costs of private professional help.

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